



Affidavit / Request for Duplicate Check

State Form 15061 (R6 / 4-00)

Approved by the State Board of Accounts 2000

Indiana State Teachers' Retirement Fund
150 West Market Street, Suite 300
Indianapolis, IN 46204-2809
Telephone: (317) 232-3860 / (888) 286-3544
Home page: <http://www.in.gov/trf>

PRIVACY NOTICE

Your Social Security number is being requested by this agency pursuant to the requirements of IRS Code 3405. This disclosure is mandatory and this form will not be processed without this information.

Social Security Number

TRF Number

Name of Applicant

I, _____, of _____,
NAME STREET ADDRESS

_____, _____, _____, do hereby make application for a
CITY STATE ZIP CODE

duplicate check to replace ORIGINAL check number _____ in the sum of \$ _____ payable

to _____ and dated _____ which

was: ☐ DESTROYED ☐ LOST ☐ OTHER . I certify that I have not received payment in any way.

If, after receiving and cashing such duplicate check, I receive the original check, I will forward it to the Indiana State Teachers' Retirement Fund immediately. I also acknowledge that if I negotiate such instrument, my future benefits may be adjusted to reimburse the Indiana State Teachers' Retirement Fund.

Signature of Applicant

Date Signed (month, day, year)

If you receive a monthly benefit check from this fund as an annuity survivor or surviving spouse, please give the deceased teacher's name.

Name of Deceased Teacher

If you are a Court Appointed Guardian receiving a monthly benefit check from this fund on behalf of a retired teacher, annuity survivor, or surviving spouse, please attach a certified copy of the official court documents. (If you have not already done so.) Please identify the retired teacher.

Name of Retired Teacher